NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

October 7, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Ave., SW
Washington, DC 20201

RE: Kentucky HEALTH 1115 Application

Dear Administrator Slavitt,

The National Women's Law Center strongly supports the Department of Health and Human Services' efforts to implement the Patient Protection and Affordable Care Act (ACA) and make quality, affordable health insurance available to millions of American women. An important component of the ACA's efforts to expand health insurance is through Medicaid expansion, which allows states to expand Medicaid to individuals up to 138 percent of the federal poverty level, providing an unprecedented opportunity to cover some of the nation's most vulnerable low-income individuals.

Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. The Center utilizes a wide range of tools—including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education—to achieve gains for women and their families in education, employment, family economic security, health, and other critical areas. The National Women's Law Center has long advocated for women's health care and reproductive rights. The Center's efforts reflect extensive research and expertise regarding women's specific health needs. It is with this expertise that these comments are respectfully submitted in response to Kentucky's proposed "Helping to Engage and Achieve Long Term Health" (HEALTH) 1115 Waiver demonstration, released on Sept. 8, 2016.

Unlike most other states with approved Medicaid waivers to date, Kentucky has successfully implemented a traditional Medicaid expansion. Since Medicaid expansion in the state in January 2014, over 400,000 Kentuckians have gained coverage under the state's traditional expansion, and the state's uninsured rate for non-elderly adults fell from 18.8 percent in 2013 to 6.8 percent in 2015, one of the largest declines in the country. [1]

Women have particularly benefited from the state's traditional Medicaid expansion. The uninsured rate for women in Kentucky has fallen below the national average to 7 percent.[2] And

[1] KAISER FAMILY FOUND., What's At Stake in the Future of the Kentucky Medicaid Expansion? (July 7, 2016), http://kff.org/medicaid/fact-sheet/whats-at-stake-in-the-future-of-the-kentucky-medicaid-expansion/.
[2] Uninsurance rates for women ages 18-64 in Kentucky calculated by NWLC based on 2015 American Community Survey, available at http://www.census.gov/programs-surveys/acs/.

significant numbers of women both below and above the poverty line gained coverage in just the first year of the traditional expansion.[3] Enrollees in the expansion are receiving preventive care at higher rates than other Medicaid enrollees in the state, are visiting emergency rooms less frequently, are having less trouble paying medical bills, and are skipping medications less frequently because of cost.[4]

In order to maintain these improvements, it is imperative that Kentucky preserve its expanded Medicaid coverage, but the deeply flawed current proposal undermines the benefits and protections achieved through the expansion Kentucky's proposed 1115 waiver would decrease, not expand, coverage and benefits for the state's vulnerable populations. Thousands of beneficiaries, including disproportionate numbers of women,[5] would lose coverage under Kentucky's proposal. Kentucky estimates that if its proposal is implemented, Medicaid enrollment will drop by over 200,000 member months in the first year, climbing to a loss of over one million member months after the first five years.[6] Further, under the pretext of cutting costs, Kentucky seeks to provide very limited benefits and require significant cost sharing for eligible beneficiaries, which goes well beyond other waivers that have been approved by the Centers for Medicare and Medicaid Services (CMS).[7] This undermines ACA's goal of ensuring that Medicaid provides quality benefits at limited costs to low-income enrollees. CMS should consider Kentucky's successful Medicaid expansion in and evaluate the projected loss of coverage and benefits to low-income enrollees under its waiver proposal, just as it did when evaluating Ohio's recent 1115 waiver application.[8]

Importantly, CMS cannot approve a wavier that would violate Section 1557 of the ACA which prohibits discrimination on the basis of race, color, national origin sex, including pregnancy, sex

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[3] Thirty-five percent of women ages 18–64 at or below 100% FPL had Medicaid coverage in 2013 compared with 51 percent in 2014. For women ages 18–64 between 100–138% FPL, 25 percent had Medicaid coverage in 2013, compared with 44 percent in 2014. Overall, an additional 63,595 women had Medicaid coverage in 2014 compared to 2013. Differences between Medicaid coverage rates between 2013 and 2014 are statistically significant at 95% confidence intervals. NWLC calculations based on ACS 2013 and ACS 2014 using IPUMS-USA, University of Minnesota, available at https://usa.ipums.org/usa/.

[4] Larisa Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review*, KAISER FAMILY FOUND. (June 20, 2016), *available at* http://kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review-issue-brief./; KAISER FAMILY FOUND., *supra* note 1.

[5] A greater proportion of women in Kentucky rely on Medicaid for health coverage than men. Twenty-five percent of Kentucky women ages 18-64 rely on Medicaid coverage compared with 20 percent of Kentucky men of the same age. This difference is even greater for women ages 25-34 years, 30 percent of whom rely on Medicaid compared to 21 percent of men in this age-range. Medicaid insurance rates for women and men ages 18-64 in Kentucky calculated by NWLC based on 2015 American Community Survey, available at http://www.census.gov/programs-surveys/acs/.

[6] Notice of Kentucky Department for Medicaid Services Public Hearings and Comment Period for §1115 Demonstration Waiver at 4, *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf.

[7] Evidence is lacking that Kentucky's traditional expansion is financially unstable. On the contrary, one report shows that in the first six months of Kentucky's expansion in 2014, the state saved $31 million. Moreover, the report found that these savings will cover all costs related to the expansion beyond fiscal-year 2021, even as the federal share of expansion costs decreases from 100 to 90 percent. Overall, the report calculates that Kentucky will save $820 million through fiscal year 2021 due to its traditional expansion. Deborah Bachrach et al., *Medicaid Expansion States See Significant Budget Savings and Revenue Gains Early Data From Two States Shows More Than $1 Billion in Savings*, STATE HEALTH REFORM ASSISTANCE NETWORK (Mar. 2015), *available at* http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/Medicaid-Expansion-States-See-Significant-Budget-Savings-and-Revenue.pdf. These savings, unlike the savings under Kentucky's waiver proposal, are not the result of less people having coverage or reduced benefits.

[8] Letter from Andrew M. Slavitt, Acting Adm'r, Centers for Medicare & Medicaid Services to John McCarthy, Medicaid Dir., Ohio Dep't of Medicaid (Sep. 9, 2016), *available at* http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-decision09092016.pdf.

stereotyping, and gender identity, age and disability.[9] In its review, CMS must consider whether any part of the wavier proposal discriminates directly or has the effect of discriminating against these protected classes. As noted in the final rule for Section 1557, " the fundamental purpose of the ACA is to ensure that health services are available broadly on a nondiscriminatory basis to individuals throughout the country."[10] Allowing Kentucky to implement a Medicaid program that discriminates would not only violate Section 1557 but would also be contrary to this fundamental purpose.

The following comments outline why CMS should deny Kentucky's 1115 waiver demonstration in its current form.

Eligibility

2.1 Populations Eligible for Kentucky HEALTH

Kentucky's proposal affects various vulnerable populations apart from non-disabled, expansion and traditional Medicaid enrollees, including Section 1931 low-income parents and caretaker relatives, pregnant women, and Medicaid and CHIP-eligible children. But certain populations – such as children, pregnant women, and "individuals determined medically frail" – are exempted from various requirements throughout the proposal. It is unclear how Kentucky will ensure that coverage and service delivery for these vulnerable populations will be seamless. Specifically, because these populations are subjected to the waiver in general but exempted from only some requirements, there may be undue delay in receiving services caused by administrative uncertainties as to which provisions are applicable and how coverage is to be administered when an individual is exempted from a provision.

2.2 Community Engagement and Employment Initiative

The *Community Engagement and Employment Initiative* program should not be approved as a part of the Kentucky HEALTH Medicaid Waiver. The demonstration proposal conditions Medicaid eligibility on an individual's work or volunteer activities. The employment condition functions as a complete barrier to health care for those who are unable to participate. CMS has made clear this condition is not allowed in Medicaid, and Kentucky's waiver goes beyond work requirements that have been proposed by other states and denied by CMS.[11]

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[9] Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 (2010).

[10] Nondiscrimination in Health Programs and Activities, Final Rule, 81 Fed. Reg. 31,376, 31,379 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

[11] Most recently see Letter from Sylvia M. Burwell, Sec. of Health and Human Servs. to Asa Hutchinson, Gov. of Ark. (Apr. 5, 2016), *available at* http://governor.arkansas.gov/images/uploads/Burwell_Letter_to_Governor.pdf. The Arizona waiver approved by CMS on September 30, 2016 allows referrals to a "state-only work search and job training program called AHCCCS Works." CMS makes clear, however, that AHCCCS Works is a separate state initiative and that "[h]ealth coverage provided by the Medicaid program and this demonstration will not be affected by this state initiative." Letter from Andrew M. Slavitt, Acting Adm'r, Centers for Medicare & Medicaid Services to Thomas Betlach, Dir., Ariz. Health Care Cost Containment Sys. (Sep. 30, 2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf.

Demonstration projects must assist in promoting the objectives of the Medicaid program and [12] programs requiring employment have no connection to the purposes of the Medicaid program. Therefore, Kentucky's proposal should be rejected. The key purpose of the Medicaid program is to provide health care services to low-income and vulnerable people who can't afford the costs of the health care services they need. CMS should reject Kentucky's *Community Engagement and Employment Initiative* program as part of the Kentucky HEALTH Medicaid Waiver.

2.4 Other Eligibility Policies

CMS should deny Kentucky's requests to impose eligibility limitations that delay or deny coverage, threatening beneficiaries' physical and financial health for no demonstrable purpose. Kentucky's proposal requires individuals to make a premium payment before coverage can begin. Individuals have up to 60 days to make their premium payment. Individuals will remain uninsured during this 60-day period. Likewise, Kentucky's request to waive retroactive eligibility for newly eligible low-income adults does not provide any demonstrative value other than to delay coverage – putting newly eligible beneficiaries at risk of medical debt and providers at risk for bad debt. Furthermore, unlike any other state's waiver proposal, Kentucky's proposal will lock out individuals for six months if they fail to complete an "annual re-determination process" for eligibility. Kentucky acknowledges that if individuals do not complete this annual process, they will be disenrolled and fall into "coverage gaps." These eligibility requirements do not further the objectives of the Medicaid program and are barriers to coverage that CMS should reject.

Kentucky HEALTH Benefits

3.2 Employer Premium Assistance Program

Should CMS approve Kentucky's proposal for mandatory participation in the proposed *Employer Premium Assistance Program*, it should ensure Kentucky honors its promise to provide wrap-around benefits, guaranteeing that Kentucky HEALTH beneficiaries have access to all Kentucky HEALTH benefits. Wrap-around coverage is essential in this program because, unlike Qualified Health Plans (QHPs), non-QHPs and large employer plans are not required to provide Essential Health Benefits (EHBs).[13] Newly-eligible Medicaid beneficiaries who enroll in Kentucky HEALTH should receive the coverage they are entitled to, and unless Kentucky guarantees wrap-around benefits to include EHBs, beneficiaries who enroll in the *Employer Assistance Program* would not be guaranteed this coverage. Kentucky must also ensure that, as promised, beneficiaries enrolled in the *Employer Assistance Program* have no more cost-sharing than the beneficiary would have if enrolled in Medicaid.

Furthermore, non-QHP plans lack the protections and standards required of the certified QHPs. QHPs are required to meet specific standards for the inclusion of essential community providers (ECPs), network adequacy, and nondiscrimination—all of which are specifically important for

[12] MEDICAID.GOV, *Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html (last visited Oct. 7, 2016).
[13] *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, *Frequently Asked Questions on Essential Health Benefits Bulletin* (2011), *available* at https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf.

women. Without defined standards and procurement processes for the private coverage purchased outside of the Marketplace, there are no criteria against which to understand if the plans will meet the health needs of women. CMS should deny Kentucky's request to use premium support outside of the Marketplace or require all plans offered as part of the private coverage option to go through the QHP certification process.

Cost-Sharing

The complexity of the Kentucky HEALTH plan and the ability of enrollees to understand the details of the plan are concerning. The current structure of the waiver requires enrollees to manage their deductible and *My Rewards* health savings accounts; understand the financial implications of health savings accounts, premiums, and cost-sharing; and, some must choose between two coverage options. The waiver application states that the deductible and health savings accounts will create "incentives for members to obtain preventive care, participate in disease management programs, and prudently manage their spending from both accounts."[14] However, this assumption does not take into account the unique challenges facing the low-income individuals this plan seeks to cover.

To "prudently manage their spending from both accounts," beneficiaries must have a high level of health literacy as well as an understanding of how health insurance operates. Research shows, though, that health insurance literacy is lower among adults living in poverty.[15] Additionally, compared to uninsured adults with family incomes above Medicaid income-eligibility, uninsured adults eligible for Medicaid are significantly less confident in their understanding of key health insurance concepts.[16]

Major components of Kentucky's waiver proposal – the *My Rewards* health savings account and the imposition of monthly premiums on beneficiaries – are modeled after Indiana's Healthy Indiana 2.0 ("HIP 2.0") plan that was implemented in 2015. Evaluation of HIP 2.0's first year shows that implementation of the waiver has not worked as planned.[17] Replication of Indiana's plan in Kentucky would keep eligible low-income individuals from enrolling and keep others from accessing the health care they need, leaving Kentuckians much worse off than they are now.

4.1.2 My Rewards Account

The waiver outlines a system by which Kentucky will rollover 50% of any remaining balance in the beneficiary's $1,000 deductible account into a *My Rewards* health savings account. Beneficiaries can also earn "incentive dollars" for their *My Rewards* account if they participate in preventive care and community engagement activities. Enrollees must use the *My Rewards*

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[14] HEALTHY Kentucky Waiver Application (Aug. 24, 2016), at 27, *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf.

[15] *See e.g.*, Genevieve M. Kenney, et al. THE URBAN INST.. *Uninsured Adults Eligible for Medicaid and Health Insurance Literacy* (Dec. 2013), *available at* http://hrms.urban.org/briefs/medicaid_experience.html.

[16] *Id.*

[17] *See* THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0: INTERIM EVALUATION REPORT (July 6, 2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf.

account to pay for important services, such as dental, vision, and non-emergency medical transportation, which are otherwise not covered. These proposals are problematic for all Medicaid enrollees and, in particular, women, and should be denied.

Deductible Account Rollover

Women will be disadvantaged by the deductible account rollover proposal. Women are more likely to manage multiple chronic conditions; have higher medical services utilization than men; are more likely to have ever visited a medical provider; and visit medical providers more frequently.[18] For women, aged 45-64, currently enrolled in public health insurance, the prevalence of 4 more chronic conditions was higher than among women with private coverage or without coverage.[19] Thus, women are less likely to have money leftover in their deductible account to rollover and will have to pay to the full premium each year. CMS must require Kentucky to address this discriminatory effect.

Incentive Program

Evaluations of incentive programs in other states that allow beneficiaries to earn rewards that reduce cost-sharing show that it is likely that few beneficiaries will actually earn rewards, leaving Kentuckians without coverage for services that are currently covered. In Indiana, beneficiaries can earn rewards by receiving preventive care, but these rewards do not appear to be working as incentives because fewer than half of all enrollees even knew they had an account.[20] Programs in Iowa and Michigan that reward beneficiaries who receive preventive care and/or receive a health risk assessment have had similar results: in Iowa, only 17 percent of enrollees with incomes below the poverty line and 8 percent with incomes above the poverty line qualified for rewards; in Michigan, only 14.9 percent of beneficiaries enrolled for at least six months completed a health risk assessment that could lower their cost-sharing charges.[21]

Further, while coverage of and access to preventive services is vital, especially for women, Kentucky's proposed approach raises privacy concerns. Conditioning the *My Rewards* account on use of preventive care services may exacerbate privacy and confidentiality concerns that already exist with respect to certain preventive care services. For example, family planning services and testing for sexually transmitted infections can raise particularly sensitive privacy concerns, which can lead people to delay or forgo seeking such care. While the *My Rewards* account proposal is meant to incentivize individuals' use of preventive services, failure to adequately protect patient privacy and ensure confidentiality may have a deterrent effect. Each of the actors involved in handling information through Kentucky HEALTH are covered entities

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[18] Brett O'Hara & Kyle Caswell, *Health Status, Health Insurance, and Medical Services Utilization: 2010*, CURRENT POPULATION REPORTS, U.S. CENSUS BUREAU (issued July 2013), *available at* https://www.census.gov/prod/2012pubs/p70-133.pdf.

[19] Brian W. Ward & Jeannine S. Schiller, *Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey, 2010*, 10 PREVENTING CHRONIC DISEASE (Apr. 15, 2013), *available at* http://www.cdc.gov/pcd/issues/2013/12_0203.htm.

[20] Judith Solomon, CTR. ON BUDGET AND POL. PRIORITIES, *Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved* (Aug. 1, 2016), http://www.cbpp.org/research/health/indiana-medicaid-waiver-evaluation-shows-why-kentuckys-medicaid-proposal-shouldnt-be#_.

[21] *Id.*

under the Health Insurance Portability and Accountability Act (HIPAA) and thus have obligations to protect patient privacy. The State must make assurances that each of these entities comply with HIPAA as they handle this sensitive patient information, in particular with respect to the *My Rewards* account system.[22]

Additionally, the structure of the My Rewards account system, in particular the "community engagement activities" rewards, disadvantages women. Under the proposal, caregiving for a "non-dependent relative or another person with a chronic, disabling health condition" constitutes a "qualifying caregiving service" that earns *My Rewards* dollars, but caregiving for a dependent does not.[23] Women are often the main caregivers in a family, for elderly dependent relatives and/or dependent children. This would make participation in the community engagement incentive program in any way other than caregiving for a dependent relative particularly difficult for many women. As a result, women may not be able to earn *My Rewards* dollars to pay for health care services. Women would have to make arrangements for child or elder care in order to participate in the qualifying activities such as searching for work or taking a class. For many families, child care can be unaffordable or unattainable; for example, the average annual cost of child care in Kentucky for a four year old is $5,499.[24] Tying *My Rewards* money – which is necessary to purchase vision and dental coverage – to community engagement, effectively penalizes women and families who cannot afford the dependent care that would allow them to search for and retain employment or education.

4.2 Member Required Contributions

Allowing Kentucky to impose monthly contributions on Medicaid beneficiaries, including those with little or no income, would greatly reduce enrollment in contravention of the key purpose of the Medicaid program: to provide health care services to low-income and vulnerable people who can't afford the costs of the health care services they need. These monthly contributions must be treated as premiums under section 1916(a)(1) of the Social Security Act.

Evaluations of Indiana's premium requirement are a helpful comparison in evaluating the potential efficacy of Kentucky's premium proposal. Indiana's HIP 2.0 demonstration requires "HIP Plus" beneficiaries to make monthly premium contributions of approximately 2% of income, ranging from $1 to $100 per month. Likewise, Kentucky's proposal imposes a monthly premium requirement based on income, with contributions for adults with incomes above poverty of $15 per month ($180 per year), increasing yearly after year two.

Evaluations of Indiana's program have shown that premiums decrease enrollment. Indiana's experience makes clear that charging premiums to people with very low incomes is not an appropriate use of demonstration authority. At the time HIP 2.0 was approved, Indiana estimated it would cover 350,000 then-uninsured Hoosiers but at the end of January 2016, only

[22] Health Insurance Portability and Accountability Act of 1996, codified in sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C..
[23] HEALTHY Kentucky Waiver Application, *supra* note 14, at 29.
[24] CHILD CARE AWARE OF AM., PARENTS AND THE HIGH COST OF CHILD CARE: 2015 REPORT 30 (2015), *available at* http://usa.childcareaware.org/wp-content/uploads/2016/05/Parents-and-the-High-Cost-of-Child-Care-2015-FINAL.pdf.

207,000 individuals were newly enrolled – well below the estimate.[25] Additionally, about one-third of eligible individuals that apply are not enrolled because they do not make a premium payment. Only two-thirds of these individuals eventually make a payment within the required 60-day period and receive coverage. This indicates that the premium contributions are preventing a significant number of eligible enrollees from receiving needed coverage.[26]

Additionally, Kentucky proposes to require premiums which will, in some cases, be more expensive than the cost of private plans would be on the Marketplace. Kentucky has proposed contributions for adults with incomes above poverty of $15 per month ($180 per year). In year three, the premium rises to $22.50 per month ($270 per year). The premium eventually rises to $37.50 per month in year five ($450 per year). After year two, these proposed contributions are higher than premiums would be for adults at the same income level on the Marketplace. The expected contribution for coverage on the Marketplace with an income at 101% of the FPL for one adult is $202 per year. In many cases, consumers would have a choice of coverage on the Marketplace that would cost them even less than the expected contribution used to calculate their premium credit. At this income level, Kentucky's proposed premiums after year two are nearly $70 more per year for a single person than the cost of coverage would be on the Marketplace. While imposing premiums at all on very low-income individuals violates the primary purpose of the Medicaid program, if they are imposed, premiums for beneficiaries enrolled in Kentucky HEALTH should not be higher than what they would be paying on the Marketplace.[27]

4.2.1 Non-Payment Penalties

Kentucky's waiver proposal would allow the state to make monthly premium payments a condition of continuing eligibility. If enrollees are unable to pay their premiums, they could be locked out of coverage for up to six months. Kentucky justifies this lockout as a way to promote personal responsibility and healthy choices, but research does not support this hypothesis. Evaluations of the Children's Health Insurance Program (CHIP) show that lockout periods reduce retention in the program and are associated with increases in disenrollment as well as decreases in reenrollment after the lockout period.[28]

Additionally, lockout periods will inevitably disrupt continuity of care, which would be particularly harmful for women, who are more likely to manage chronic conditions. If lockout periods are imposed on beneficiaries, women would also experience major disruptions in access to critical services such as contraception and other timely family planning services. CMS should deny Kentucky's proposal to create a lockout period for nonpayment of premiums.

[25] Solomon, supra note 20.
[26] *Id.*
[27] Based on Healthcare Marketplace calculator with 1 adult age 30, in Kentucky, *available at* https://www.healthcaremarketplace.com/health-insurance-tax-credit-calculator.
[28] Margo Rosenbach et al, MATHMATICA POL. RESEARCH, INC., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access* (Sept. 2007), *available at* http://www.mathematica-mpr.com/publications/pdfs/schipdecade.pdf.

List of Proposed Waivers

8.1 Title XIX Waivers

The Kentucky proposal would allow the state to limit Medicaid enrollees' freedom to seek care from the provider of their choice for all services, including family planning services and supplies. This limitation would also mean that the state would not need to pay for services provided out-of-network. The Medicaid statute, regulations, and CMS guidance have recognized states' heightened obligations with regard to access to family planning services.[29] Section 1902(a)(23)(B) of the Social Security Act guarantees that Medicaid beneficiaries can receive family planning services from any qualified Medicaid provider, even if the provider is outside of their Medicaid managed care network. In Iowa's 1115 waiver approval, CMS required that "[f]amily planning services that the QHP considers to be out-of-network, subject to all third party liability rules, will be ensured by the state Medicaid program to be paid at state plan rates.."[30] CMS should require Kentucky to meet the same standard for Kentucky HEALTH enrollees and other Kentucky Medicaid beneficiaries.

Thank you for the opportunity to submit comments on Kentucky's 1115 waiver for the Kentucky HEALTH Plan. Kentucky's efforts to maintain its expanded coverage are commendable but its approach raises serious concerns, which CMS should address by denying waiver approval.

Sincerely,

Fatima Goss Graves, Senior Vice President for Program
National Women's Law Center

[29] *See, generally*, CENTERS FOR MEDICARE & MEDICAID SERVICES, *SMD # 16-005 Re: Clarifying "Free Choice of Provider" Requirement in Conjunction with State Authority to Take Action against Medicaid Providers* (Apr. 19, 2016), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf.
[30] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Special Terms and Conditions, Iowa Marketplace Choice Plan*, (July 31, 2015), at 12, *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf.